TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
XL Specialty Insurance Co

MFDR Tracking Number
M4-17-0197-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 08/12/2016 the appeal was issued a partial payment in the amount of $60.88. Per EOB it stated that the amount paid reflects the usual and customary charge. On 08/24/2016 we sent our appeal for payment, including all supporting documentation and including authorization #12245818."

Amount in Dispute: $74.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on October 4, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2016	E0730, RR	$74.12	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

3. Texas Labor Code 408.0284 sets out network provisions for durable medical equipment.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Service to be reviewed for payment by DME informal or voluntary network, Coventry DMEplus as defined in Texas Labor Code 408.0284. Contact DMEplus at dmebilling@cvty.com or 877-398-9938 with inquiries
   - 1 – The amount paid reflects the usual and customary charge. (P301).
   - 2 – Formatted EOR Message unavailable. Event Message – No reduction available
   - 3 – The charge for this procedure exceeds the customary charges by other providers for this service. (Z711)
   - 999 – Formatted EOR Message unavailable. Event Message – PPO determined by MCPS
   - 1 – This item was previously submitted and reviewed with a notification of decision issued to payor, provider (duplicate invoice) (U301)

Issues

1. Is the insurance carrier's denial/reduction supported?
2. How is the applicable workers' compensation fee guideline calculated?
3. What is the maximum allowable reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $74.12 for the submitted code E0730 , RR – "Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation," rendered on July 6, 2016. The insurance carrier denied the charges with claim adjustment reason code 1 – "Service to be reviewed for payment by DME informal or voluntary network."

   Upon reconsideration, this denial was not maintained. Therefore, this denial will not be considered in this review.

   At the time of reconsideration, the insurance carrier paid $60.88 reducing the charge as 1 – "The amount paid reflects the usual and customary charge" and 3 – "The charge for this procedure exceeds the customary charges by other providers for this service."

   The Division will review the request for additional reimbursement based on the applicable fee guideline discussed below.

2. To determine the maximum allowable reimbursement the following four steps must be followed.

   i. Determine the current DME MAC Jurisdiction C fee schedule which is published by Cigna Government Services (CGS), located at http://www.cgsmedicare.com/medicare_dynamic/fees/jc/search.asp.

   ii. Locate the fee amount and payment category by searching the data base for the fees for your HCPCS code. Note the fee schedule amount for the service that you billed (including modifier), and note the Category.

   iii. Review the Medicare policy for the payment category at the current Medicare Claims Processing Manual, Chapter 20 – Durable Medical Equipment (DMEPOS) located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf, to look up the Medicare payment policy that applies to the Category.

   iv. The Texas workers compensation fee guideline outlined in 28 Texas Administrative Code §134.203 defines the reimbursement rate(s) for durable medical equipment and can be located at, http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=2&ch=134&rl=203.

   The specifics of this rule are detailed below;

   > (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

For the service in dispute the applicable Medicare payment policy is found in the Medicare Claims Processing Manual, Chapter 20, Section 30.1.2, which states in pertinent part,

Pay 10 per cent of the purchase price for each of 2 months.

28 Texas Administrative Code §134.203 (d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

The 2016 3rd Quarter Texas DMEPOS Fee Schedule at www.cgs.medicare.com, finds the allowable for E0730 to be $64.58.

Per the above, this allowable divided by 10 equals a monthly allowable for the first two months of $6.46.

Therefore pursuant to provisions of Rule 134.203(d)(1) the monthly allowable is ($6.46 x 125%) = $8.08.

3. The maximum allowable for the services in dispute is $8.08. The carrier paid $60.88. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November 17, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.